Pan Berkshire Response to the New Child Death Statutory and Operational Guidance

(Oct 2018)

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Berkshire West Safeguarding Children Partnership
Reading | West Berkshire | Wokingham

Slough Local Safeguarding Children Board

Bracknell Forest Local Safeguarding Children Board

Windsor and Maidenhead Local Safeguarding Children Board

Forward/ Introduction

A joint Child Death Overview Panel has run across Berkshire since 2008. We have learned a lot in that time and we believe the way we have applied that learning has helped us change the way we work for the better. Our aim is to improve prevention of child deaths and to better support families who find themselves in the truly tragic circumstances of losing a child and we remain committed to continuing that journey of learning and improving.

Thankfully, child deaths are uncommon in Berkshire, and we welcome the development of the National Child Mortality Database to enable more detailed analysis and interpretation of the data arising from the child death review process. The Child Death Review Statutory and Operational Guidance published in October 2018 sets out the key features of a good review process when a child dies, combining both statutory requirements and best practice. We want to play our part in following the guidance to standardise practice nationally to learn more in order to prevent future deaths.

As a local partnership of NHS organisations, local authorities, the police and third sector organisations, we have reviewed our local processes. We have in place strong processes for child death investigations and reviews but we do need to make some changes in order to align our practice and processes with the new guidance. We have looked in detail at the guidance and our local process and identified a number of improvements we would like to make.

Below, we have set out further information on the review that resulted in the changes we intend to make here, with a view to being operational by September 2019.

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Background and Context

In 2008, Child Death Overview Panels (CDOPs) were statutorily established in England under the aegis of Local Safeguarding Children Boards (LSCBs) with the responsibility of reviewing the deaths of all children (0 to <18 years) in their resident population.

In Berkshire the CDOP is a subgroup of the six Unitary Authority Local Safeguarding Children Boards arrangements. It is made up of representatives from across the county from a range of organisations, including health, social care and police.
The purpose of the CDOP, (as required by the Local Safeguarding Children Boards Regulations 2006) is to collect and analyse information about each child death in order to:

- Identify any changes that we can make or actions we can take that might help to prevent similar deaths in the future.
- Share learning with colleagues regionally and nationally so the findings will have wider impact.

In October 2018 new guidance from Government titled 'Child Death Review (CDR) Statutory and Operational Guidance' has set out the key features of a good review process when a child dies, combining both statutory requirements and best practice. This is will illustrated as a process in the appendix (page 10). Full guidance is located:
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The guidance should be followed by all organisations involved with the process of child death reviews in England, in order to standardise practice nationally and enable thematic learning to prevent future deaths. Key statutory partners were tasked with reviewing and responding to NHS England to assure them that the guidance procedure and practise expectations are in place by September 2019.

Berkshire statutory partners have completed a review of current arrangements and have taken these findings through CDOP executive members, Local Authority Children's Services Director of Children's Services and Clinical Commissioning Group (CCG) safeguarding leads. This document details Berkshire's response and either provides assurance that procedures and practise are already in place and meets the guidance expectations, or that there is a plan for the necessary changes to be implemented by end of September 2019. Our response follows the key areas of the guidance, as detailed in the table below.

Page	Areas of Guidance
4	Geographical area of CDR coverage
5	Immediate notification and decision making
6	Investigation and information gathering
7	Family Engagement and Bereavement Support
8	Child Death Review meeting
9	Child Death Overview Panel

Our Review and Findings

Berkshire West and Berkshire East have in place existing and mainly good processes for child death investigation and reviews. However the new guidance has required that a local review is completed to ensure we are either compliant or need to make changes or improvements to meet the new standards and expectations. Both CCGs (West and East) have worked together to complete review with the support of key partners already involved in the CDR processes and actions.

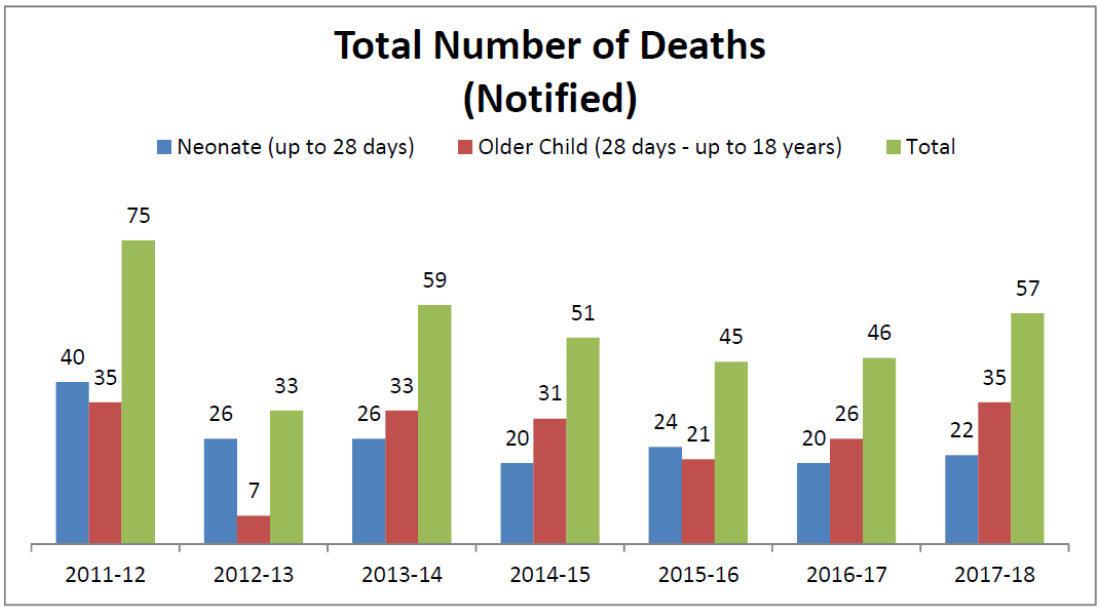
The review looked at 3 areas:

a. Confirmation of CDOP practise processes that are already compliant
b. Identification of changes that are required to current practise/ processes with the solution identified for consultation to implement by end of September 2019
c. Identification of gaps in current offer/ processes with a plan to meet this identified gaps that therefore create a solution by end of September 2019.

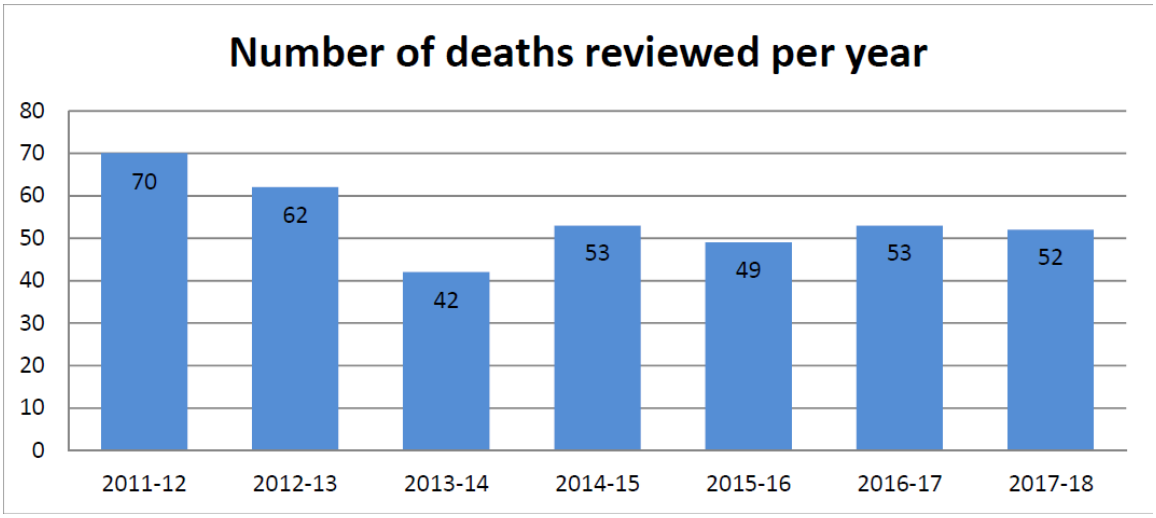
With the review completed the Pan Berkshire Child Death Overview Panel have set out a number improvements in each stage of the process it will make on the key areas of the new guidance that it will put in place by the end of September 2019.

Section 1 – Geographical Coverage of the CDR area

The guidance recommends that the CDR should cover a child population to be able to review at least 60 child deaths a year (section 5.1.2 of the CDR guidance). The number of child deaths reviewed by Berkshire has been typically around 50, although the 18/19 number was lower at 34.



An alternative measure of activity within CDOP to look at the number of deaths reviewed by panel. The most recent year 18/19 CDOP reviewed 43 deaths (with 18 still outstanding) and table below outlines the last 7 years of reviews completed per year.



Conclusion from review is to continue to use Berkshire as the CDR footprint (no change to current arrangements).

Section 2 - Immediate notification and decision making

(*guidance focuses on the immediate actions to be taken after the death of a child, such as notification of death, or deciding whether other investigations are warranted. In practice, the majority of such discussions will happen in a clinical setting, but may require input from other agencies in certain cases)*

The review has concluded that;

- For both the East and West CCG areas the majority of current arrangements are compliant with the new guidance.
- Key decisions are made within the timeframes expected on determination of the whether a Joint Agency Response is required and initiated, determine whether a Medical Certificate of Cause of Death (MCCD) can be issued or whether death should be referred to the coroner.
- There is assurance that other key statutory child protection agencies are included in these decisions as required, led by either the Designated doctor for child death (East) or the Designated Professional for Child Death (West).
- There is no requirement to change the criteria for instigating a Joint Agency Response, as the currently used criteria for Rapid Response for unexpected deaths can continue to be used.
- There is an action to ensure that the criteria can be used against all deaths.
- The majority of notifications that need to be made are done with assurance. There is a need to provide some training updates for key staff, including GPs on ensuring there is an even greater notification completion of Form A on time and accurately.

It has been concluded that The Rapid Response Meeting should be renamed to the Joint Agency Response meeting.

Improvements we intend to make are to organise more briefings/ training to support further improvement in notification form completion.

Section 3 - Investigation and information gathering

(*Guidance focus's predominantly for those involved in the preliminary stages of the child death review process in the aftermath of a child's death. It also summarises other investigations that may run in parallel to the CDR process.)*

The review concluded that;

- The coroner investigation process has a clear and communicated referral criteria and process. Information sharing is good with the ability to escalate as required when this is an issue.
- The coroner's office has confirmed they liaise closely with families throughout the process, that they are accessible every day of the year and can organise early release of the body as noted in the guidance. There is no change required in this aspect of the guidance.
- The Joint Agency Response process (known currently as the Rapid Response process) is delivering to the expectations and timeframes in the new guidance.
- The local SUDI/C policy is in place and is in line with national guidance having been reviewed recently (West only). No change is required here, but action for end of Sept 19 is to ensure this policy is consistent/ standardised with the new guidance.
- Joint health and police home visiting is noted as good practise to provide health advice and expertise when relevant to an investigation process. This health service is CCG commissioned with BHFT and will be available before end of September 2019. The expectation is that the Police will assess and then request this Health support from BHFT.
- NHS notifications systems in place for serious incident investigations within the provider NHS Trusts as outlined the guidance.

The conclusion is that the Joint Agency Response meeting (newly named) will continue to work to the same structure and process as the current Rapid Response meetings, with templates being updated by Sept 2019.

The improvement we intend to make is that the JAR meeting should include a discussion to decide whether information about each case needs to be shared with the relevant Local Authority. This will support the Local Authority decision to notify the Child Safeguarding Practice Review Panel (if the case meets the criteria for notification).

Section 4 – Family Engagement and Bereavement Support

(The guidance recognises the complexity of the process, and the different emotional responses that bereavement can bring. Guidance expects that families should be given a single, named point of contact, i.e. the "key worker", for information on the processes following their child's death, and who can signpost them to sources of support.)

The guidance places greater emphasis and expectation on all staff and partners to provide support to families, showing kindness and compassion to bereaved parent, carers and siblings.

A fundamental change is to ensure that all families are offered a Key Worker who essentially is a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support.

The review concluded that within Berkshire the offer of a key worker will depend on the circumstances of the child death. Therefore:

- When a Police investigation is initiated for suspected homicide then the Family Liaison Officer will provide that role.
- Where a Joint Agency Response process is initiated it is proposed that this is the meeting that discusses and resolves who is best placed to take on this role for the family.
- When a child death does not warrant a Joint Agency Response there are some child death circumstances that provide a clear / obvious option:
    - Neo-natal and under 28 days – Bereavement Midwife
    - Planned end of life – Children's Community Nurse
- It is proposed that when there is a child death and no key worker is available or cannot be accessed there needs to be an escalation process through the Designated Doctor for Child Death (East) and Designed Professional for Child Death (West) and onto the CCG safeguarding team.
- The expectation is that a key worker is nominated by the end of the first Joint Agency Response meeting or shortly afterwards. Or if there is no JAR initiated the aim is to still identify the key worker within 48 hours. At times this may not be possible and the escalation process may be required to be used.
- Within both Acute trusts, running Accident and Emergency units, there is agreement to offer immediate support to the family whilst a key worker is identified. The exact nature of the support is to be confirmed before the end of September 2019.

Improvements we intend to make are to formally introduce nominated key workers, as described above.

Section 5 - Child Death Review meeting

(*Guidance states that this meeting is a discussion of the death of a child by the professionals who were directly involved in the care of that child during his or her life and those professionals who were involved in the investigation into his or her death. The outputs of this meeting will inform the statutory independent multi-agency panel arranged by CDR partners at CDOP or equivalent.)*

This meeting will be provided for every child death. This is a new expectation in the guidance and there are a number of solutions within both CCG areas.

The CDR meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay. The child death review meeting should occur before the coroner's inquest, child safeguarding practice review and the CDOP review.

The review concluded that Child Death Review meetings to be held through these formats:

- A final case discussions following Joint Agency Response will be added to the process, as coordinated by the Designated Child Death Doctor (Berkshire East) or Lead Professional for Child Death (Berkshire West), chaired by these roles.
- Perinatal mortality review group meetings in the case of a baby who dies in a neonatal unit, this will be chaired by the relevant clinical consultant lead in the Acute Trust, managing as usual any perceived conflict of interest circumstances.
- Hospital Mortality Review Meetings following the death of a child in hospital, or similar case discussion, this will be chaired by the relevant clinical consultant lead in the Acute Trust, managing as usual any perceived conflict of interest circumstances.
- Guidance should be written to support the Chairs of these CDR meetings to ensure consistency and quality of the information that is then submitted onto the eCDOP system.
- The Chair of each of these meeting is responsible ensuring that the details of each child death review meeting should be captured on a draft 'child death analysis form' (formally Form C) and uploaded onto the eCDOP system. This needs to be finalised with the Chairs of each of the relevant meetings.
- Within Berkshire there are already established procedures with the local Learning Disabilities Mortality Review (LeDeR) set up, that meets guidance expectations.

The improvements we intend to make are:

- **To ensure that a CDR meeting is held for all child deaths, to local guidance, that is then reported on the eCDOP system in preparation for CDOP review.**
- **To confirm that 2 existing meetings (Perinatal mortality review group & Hospital Mortality Review) within Acute trusts adopt the responsibility of completing the CDR meeting, and to identify and agree who will be responsible for completing a child death analysis form and submit to eCDOP.**
- **To confirm that the JAR coordinators for Berkshire East and West add a final review meeting to the process to complete the CDR meeting with the involved professionals.**

Section 6 – Child Death Overview Panel (CDOP)

(*The Guidance outlines some of the statutory requirements placed upon CDR partners. It outlines the function of an independent and multi-agency panel that should be established to scrutinise all aspects of a child's death, using evidence generated in the steps which precede this stage of the overall child death review process. This is known as a Child Death Overview Panel (CDOP) or equivalent.)*

The review concluded that:

- Berkshire has a well formed and functioning CDOP. As already proposed (page 3) the geographical area for the panel will remain the same.
- The outlined functions of the panel in the guidance are already being met and will continue to be met.

The conclusion is to keep the CDOP arrangements as currently set up, but to review panel membership and explore more themed panels.

Appendix A:

The Child Death Review Process